subpart E of this part. The MSR for an ACO under Track 3 is the same as the MSR that would apply in the one-sided model under §425.604(b) and is based on the number of assigned beneficiaries. The MLR under Track 3 is equal to the negative MSR.

(2) To qualify for shared savings under Track 3, an ACO's average per capita Medicare expenditures for the performance year must be below its updated benchmark costs for the year by at least the MSR established for the ACO.

(3) To be responsible for sharing losses with the Medicare program, an ACO's average per capita Medicare expenditures for the performance year must be above its updated benchmark costs for the year by at least the MLR established for the ACO.

(c) *Qualification for shared savings payment.* To qualify for shared savings, an ACO must meet the minimum savings rate requirement established under paragraph (b) of this section, meet the minimum quality performance standards established under §425.502, and otherwise maintain its eligibility to participate in the Shared Savings Program under this part.

(d) *Final sharing rate.* An ACO that meets all the requirements for receiving shared savings payments under Track 3 will receive a shared savings payment of up to 75 percent of all the savings under the updated benchmark, as determined on the basis of its quality performance under §425.502 (up to the performance payment limit described in paragraph (e)(2) of this section).

(e) *Performance payment.* (1) If an ACO qualifies for savings by meeting or exceeding the MSR, the final sharing rate will apply to an ACO's savings on a first dollar basis.

(2) The amount of shared savings an eligible ACO receives under Track 3 may not exceed 20 percent of its updated benchmark.

(f) *Shared loss rate.* The shared loss rate—

(1) For an ACO that is required to share losses with the Medicare program for expenditures over the updated benchmark, the amount of shared losses is determined based on the inverse of its final sharing rate described in §425.610(d) (that is, 1 minus the final shared savings rate determined under §425.610(d));

(2) May not exceed 75 percent; and

(3) May not be less than 40 percent.

(g) *Loss recoupment limit.* The amount of shared losses for which an eligible ACO is liable may not exceed 15 percent of its updated benchmark as determined under §425.602.

(h) *Notification of savings and losses.* (1) CMS notifies an ACO in writing regarding whether the ACO qualifies for a shared savings payment, and if so, the amount of the payment due.

(2) CMS provides written notification to an ACO of the amount of shared losses, if any, that it must repay to the program.

(3) If an ACO has shared losses, the ACO must make payment in full to CMS within 90 days of receipt of notification.

[80 FR 32842, June 9, 2015]

§425.612 Waivers of payment rules or other Medicare requirements.

(a) *General.* CMS may waive certain payment rules or other Medicare requirements as determined necessary to carry out the Shared Savings Program under this part.

(1) *SNF 3-day rule.* For performance year 2017 and subsequent performance years, CMS waives the requirement in section 1861(i) of the Act for a 3-day inpatient hospital stay prior to a Medicare-covered post-hospital extended care service for eligible beneficiaries prospectively assigned to ACOs participating in Track 3 that receive otherwise covered post-hospital extended care services furnished by an eligible SNF that has entered into a written agreement to partner with the ACO for purposes of this waiver. All other provisions of the statute and regulations regarding Medicare Part A post-hospital extended care services continue to apply.

(i) ACOs must submit to CMS supplemental application information sufficient to demonstrate the ACO has the capacity to identify and manage beneficiaries who would be either directly admitted to a SNF or admitted to a SNF after an inpatient hospitalization of fewer than 3-days in the form and manner specified by CMS. Application

materials include but are not limited to, the following:

(A) Narratives describing how the ACO plans to implement the waiver. Narratives must include the following:

(*1*) The communication plan between the ACO and its SNF affiliates.

(*2*) A care management plan for beneficiaries admitted to a SNF affiliate.

(*3*) A beneficiary evaluation and admission plan approved by the ACO medical director and the healthcare professional responsible for the ACO's quality improvement and assurance processes under § 425.112.

(*4*) Any financial relationships between the ACO, SNF, and acute care hospitals.

(B) A list of SNFs with whom the ACO will partner along with executed written SNF affiliate agreements between the ACO and each listed SNF.

(C) Documentation demonstrating that each SNF included on the list provided under paragraph (a)(1)(i)(B) of this section has an overall rating of 3 or higher under the CMS 5-star Quality Rating System.

(ii) In order to be eligible to receive covered SNF services under the waiver, a beneficiary must meet the following requirements:

(A) Is prospectively assigned to the ACO for the performance year in which they are admitted to the eligible SNF.

(B) Does not reside in a SNF or other long-term care setting.

(C) Is medically stable.

(D) Does not require inpatient or further inpatient hospital evaluation or treatment.

(E) Have certain and confirmed diagnoses.

(F) Have an identified skilled nursing or rehabilitation need that cannot be provided as an outpatient.

(G) Have been evaluated and approved for admission to the SNF within 3 days prior to the SNF admission by an ACO provider/supplier who is a physician, consistent with the ACO's beneficiary evaluation and admission plan.

(iii) SNFs eligible to partner and enter into written agreements with ACOs for purposes of this waiver must do the following:

(A) Have and maintain an overall rating of 3 or higher under the CMS 5-star Quality Rating System.

(B) Sign a SNF affiliate agreement with the ACO that includes elements determined by CMS including but not limited to the following:

(*1*) Agreement to comply with the requirements and conditions of this part, including but not limited to those specified in the participation agreement with CMS.

(*2*) Effective dates of the SNF affiliate agreement.

(*3*) Agreement to implement and comply with the ACO's beneficiary evaluation and admission plan and the care management plan.

(*4*) Agreement to validate the eligibility of a beneficiary to receive covered SNF services in accordance with the waiver prior to admission.

(*5*) Remedial processes and penalties that will apply for non-compliance.

(2) [Reserved]

(b) *Review and determination of request to use waivers.* (1) In order to obtain a determination regarding whether the ACO may use waivers under this section, an ACO must submit a waiver request to CMS in the form and manner and by a deadline specified by CMS.

(2) An ACO executive who has the authority to legally bind the ACO must certify to the best of his or her knowledge, information, and belief that the information contained in the waiver request submitted under paragraph (b)(1) of this section is accurate, complete, and truthful.

(3) CMS evaluates an ACO's waiver request to determine whether it satisfies the requirements of this part and approves or denies waiver requests accordingly. Waiver requests are approved or denied on the basis of the following:

(i) Information contained in and submitted with the waiver request by a deadline specified by CMS.

(ii) Supplemental information submitted by a deadline specified by CMS in response to a CMS request for information.

(iii) Screening of the ACO, ACO participants, ACO providers/suppliers, and other individuals or entities providing services to Medicare beneficiaries in accordance with the terms of the waiver.

(iv) Other information available to CMS.

(4) CMS may deny a waiver request if an ACO fails to submit requested information by the deadlines established by CMS.

(c) *Effective and termination date of waivers.* (1) Waivers are effective upon CMS notification of approval for the waiver or the start date of the participation agreement, whichever is later.

(2) Waivers do not extend beyond the end of the participation agreement.

(3) If CMS terminates the participation agreement under § 425.218, the waiver ends on the date specified by CMS in the termination notice.

(4) If the ACO terminates the participation agreement, the waiver ends on the effective date of termination as specified in the written notification required under § 425.220.

(d) *Monitoring and termination of waivers.* (1) ACOs with approved waivers are required to post their use of the waiver as part of public reporting under § 425.308.

(2) CMS monitors and audits the use of such waivers in accordance with § 425.316.

(3) CMS reserves the right to deny or revoke a waiver if an ACO, its ACO participants, ACO providers/suppliers or other individuals or entities providing services to Medicare beneficiaries are not in compliance with the requirements of this part or if any of the following occur:

(i) The waiver is not used as described in the ACO's waiver request under paragraph (b)(1) of this section.

(ii) The ACO does not successfully meet the quality reporting standard under subpart F of this part.

(iii) CMS identifies a program integrity issue affecting the ACO's use of the waiver.

(e) *Other rules governing use of waivers.* (1) Waivers under this section do not protect financial or other arrangements between or among ACOs, ACO participants, ACO providers/suppliers, or other individual or entities providing services to Medicare beneficiaries from liability under the fraud and abuse laws or any other applicable laws.

(2) Waivers under this section do not protect any person or entity from liability for any violation of law or regulation for any conduct other than the conduct permitted by a waiver under paragraph (a) of this section.

(3) ACOs must ensure compliance with all claims submission requirements, except those expressly waived under paragraph (a) of this section.

[80 FR 32843, June 9, 2015]

Subpart H—Data Sharing With ACOs

§ 425.700 General rules.

(a) CMS shares aggregate reports with the ACO.

(b) CMS shares beneficiary identifiable data with ACOs on the condition that the ACO, its ACO participants, ACO providers/suppliers, and other individuals or entities performing functions or services related to the ACO's activities observe all relevant statutory and regulatory provisions regarding the appropriate use of data and the confidentiality and privacy of individually identifiable health information and comply with the terms of the data use agreement described in this subpart.

(c) The ACO must not limit or restrict appropriate sharing of medical record data with providers and suppliers both within and outside the ACO in accordance with applicable law.

§ 425.702 Aggregate reports.

CMS shares aggregate reports with ACOs as follows:

(a) Aggregate reports are shared at the start of the agreement period based on beneficiary claims data used to calculate the benchmark, and each quarter thereafter during the agreement period.

(b) These aggregate reports include, when available, the following information, deidentified in accordance with 45 CFR 164.514(b):

(1) Aggregated metrics on the assigned beneficiary population.

(2) Utilization and expenditure data at the start of the agreement period based on historical beneficiaries used to calculate the benchmark.

(c)(1)(i) For performance years 2012 through 2015, at the beginning of the agreement period, during each quarter (and in conjunction with the annual reconciliation), and at the beginning of